1. Lines 11, 20, 29, 41, 50, 59, and 66 shall be completed by Hospital-Based Providers only. The purpose of these lines shall be to compute each ancillary cost center's share of plant operations and maintenance, housekeeping and capital costs. The Column 7 amounts are derived by multiplying the appropriate Hospital Ancillary Square Foot Percentage (Schedule F, Statistic B, Column 4) by the amount on Schedule D-4, Line 24, Column 9.

G. Column 8: This column shall be used for reporting the Certified Cost Based Nursing Facility's share of indirect cost. For each ancillary cost center, multiply the appropriate Certified Cost-based facility Ancillary Charge Percentage (Schedule F, Statistic D, Column 3) times the amounts reported in Column 7 to arrive at the correct amounts for Column 8.

SECTION 11. SCHEDULE D-6-RECLASSIFICATION OF EXPENSES

This work sheet provides for the reclassification of certain amounts necessary to effect proper cost allocation under cost finding. All providers that do not direct cost payroll fringe benefits to individual cost centers shall use this schedule to allocate fringe benefits to the various cost centers. Fringe benefits shall be reclassified to individual cost centers on the ratio of the salaries unless another, more accurate and documentable method can be determined. The reclassification to each cost center shall be entered to the appropriate Schedule D-1 through D-5 line titled " Employee Benefits Reclassification."

SECTION 12. SCHEDULE D-7-ADJUSTMENT TO EXPENSES

This schedule details the adjustments to the expenses listed on Schedule D-1 through D-5, column 4. Line descriptions indicate the nature of activities, which affect allowable costs as defined in this manual or result in costs incurred for reasons other than resident care, and thus require adjustment. Lines 22 through 52 are provided for other adjustments not specified earlier. A brief description shall be provided.

The adjusted amount entered in Schedule D-7, column 3, shall be noted "A" in Schedule D-7, column 2, when the adjustment is based on costs. When costs are not determinable, "B" shall be entered in column 2 to indicate that the revenue received for the service is the basis for the adjustment.

SECTION 13. SCHEDULE E - ANCILLARY SETTLEMENT

This schedule is designed to determine the Medicaid share of direct and indirect ancillary costs.

A. Column 2: Enter direct ancillary cost for each ancillary cost center from Schedule D-5, Column 6.

B. Column 3: Multiply the direct costs (Column 2) by the corresponding Medicaid charge percentages (Schedule F, Section D, Column 5, Lines 1 through 7).

C. Column 4: Enter the total amount received from the Medicaid Program (including any amount receivable from the Medicaid Program at the report date) for ancillary services rendered to Medicaid Certified Cost-based facility recipients during the period covered by the cost report.

D. Column 5: Subtract the Column 5 amount from the Column 4 amount and enter the difference in Column 6.

SECTION 14. SCHEDULE F - ALLOCATION STATISTICS

A. Section A - Nursing Hours or Salaries
This allocation statistic shall be used as the basis for allocating the line item costs reported to Schedule D-1, Lines 1-33; Schedule D-2, Lines 1-30; and D-3, Lines 57-130, which cannot be direct, costed to the levels of care. The allocation statistic may be based on the ratio of direct cost of nursing salaries, the ratio of direct nursing hours, a valid time study (as defined by the Department for Medicaid Services), another method which has been approved by the Department for Medicaid Services or, if no other reasonable basis can be determined, resident days. The computation of this statistic shall account for the direct salary costs associated with all material non-certified nursing activities of the facility (such as adult day care or home health services, for example). The computed statistic shall be reasonable and based on documented data. The method used in arriving at the allocation shall be identified at the appropriate place on Schedule F, Ratio A. For Hospital-Based Facilities Only: The salary costs of all departments and services of the hospital, including all ancillary departments as defined in the general policies and principles of the

Department for Medicaid Services, shall be included in the calculation of this statistic. Allocations of costs between Certified Cost-based facility and acute cost centers on the basis of resident days will be accepted only when the
resulting allocation statistic can be documented and shown to be reasonable.

1. Line 1: Enter the Certified Cost-based facility figure (i.e., salaries or direct hours)
2. Line 2: Enter the "Other" nursing and direct service figure (i.e. salaries or direct hours)
3. Line 3: Divide Line 1 by the sum of Lines 1 and 2 and enter the percentage on Line 3. The percentage shall be carried out to four decimal places (i.e. xx.xxxx%).
4. NOTE: If salary cost figures are used in computing this allocation statistic, the amounts entered in Lines 1 and 2 shall usually agree to entities on the salary lines of Schedule D-1. If the Schedule F, Ratio A salary figures do not agree to Schedule D-1 salary lines, providers shall review both schedules to ensure that both schedules are correct. The provider shall be able to reconcile Schedule F, Ratio A to Schedule D-1 salary lines upon request.

B. Section B - Square Footage

1. Freestanding facilities shall only complete Columns 1 and 2 of this section. Hospital facilities shall complete all four columns.

   a. Column 1, Lines 1-10: Enter the square feet in each applicable area of the facility. Direct resident room areas shall be allocated between Certified Cost-based facility and "Other" (PC, Non-certified, Acute, etc.). General resident areas, such as hallways, nursing stations, lounges, etc., which are utilized 100% by one level of care shall be directly allocated to the appropriate cost center. General resident areas used by more than one level of care and general service departments (administrator offices, dietary areas, etc.,) shall be allocated between levels of care based on the ratio of Certified Cost-based facility
   room square footage to total room square footage. In freestanding facilities, ancillary departments shall be

considered general service departments and allocated to levels of care. In Hospital-Based facilities, direct ancillary square footage shall be entered on Lines 3 through 8.

b. Column 2, Lines 1-10: Percentages in Column 2 shall be derived by dividing Column 2, Lines 1 through 9, by Line 10 of Column 1. Line 10 shall be the sum of Lines 1 through 9 and should equal 100.0000%.

2. Columns 3 and 4 shall only be completed by Hospital-Based Facilities. These two columns compute allocation factors to allocate the indirect ancillary costs allocated to the pooled ancillaries in Column 9 of Schedules D-3 and D-4 to the individual ancillary cost centers on Schedule D-5.

a. Column 3, Lines 3-9: The entries to these lines shall be identical to the entries on the same line number of Ratio B, Column 1.

b. Column 3, Line 10: The entry to this line shall be the sum of the entries to Lines 3-9.

c. Column 4, Lines 3-9: The entries to these lines shall be the percentages resulting from dividing the direct square footage allocated to each ancillary service in Column 3, Lines 3-9 by the total direct ancillary square footage computed at Column 3, Line 10. Percentages shall be carried to four digits (i.e., xx.xxxx%).

d. Column 4, Line 10: The entry to this line shall be the sum of Column 4, Lines 3-9 and shall equal 100.0000%.

C. Section C - Dietary

Identify the method used in arriving at the number of meals served. An actual meal count for 3 X in resident days shall be used. If 3 X inresident days is used, the provider shall ensure that bed reserve days are not included in this calculation.

1. Column 1: Enter total meals in each category.
2. Column 2: To arrive at percentages, divide Lines 1 and 2 in Column 1 by Line 3 in Column 1.

D. Section D - Ancillary Charges

1. Column 1: Enter the total charges for each type of ancillary service on Lines 1 through 7. Add Lines 1 through 7 and enter total on Line 8.
2. Column 2: Enter the total charge for each type of ancillary service provided to all Certified Cost-based facility residents (both Medicaid and non-Medicaid) on Lines 1 through 7. Add Lines 1 through 7 and enter the sum to Line 8.
3. Column 3: For each Line 1 through 8 divide total CNF resident charges as reported in Column 2 by the total resident charges (all facility residents)
reported in Column 1. Enter the resulting percentage in column 3. Percentages shall be carried to four decimal places (i.e., xx.xxxx%).
4. Column 4: Enter the total charges for each type of ancillary service provided to Medicaid residents in certified beds on Lines 1 through 7. Add Lines 1 through 7 and total on Line 8.
5. Column 5. For each Line 1 through 8 divide Medicaid charges in Column 4 by total charges in Column 1. Enter the resulting percentage in Column 3. Percentages shall be carried out to four decimals (i.e. xx.xxxx%).

E. Section E - Occupancy Statistics

1. Lines 1 and 2. Enter the number of licensed bed days. Temporary changes due to alterations, painting, etc. do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of licensed beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, actual bed days shall be used.
3. Line 4. Enter resident days for all residents in the facility. A resident day shall be the care of one resident during the period between one census taking period on two successive days, including bed reserve days. The day of admission shall be included and the day of discharge excluded. Do not include both. When a resident is admitted and discharged on the same day, this period shall be counted as one day.

4. Line 5. Percentage of occupancy shall be the percentage obtained by dividing total resident days by bed days available. The percentage calculation shall not be carried beyond one decimal place (xx.x%).
5. Line 6. A Medicaid resident day of care shall be an inresident or bed reserve day covered under the Medicaid Program. A resident days covered by the Medicare Program for which a co-insurance or deductible is made by the Medicaid Pr

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For The Period from _____ Status
to _____ Leap Year ☐ 365 ☐

A. Type of Control

1. Voluntary Non-Profit
   - Church ☐
   - Other(Specify) ☐
   - _____
   - _____
2. Proprietary
   - Individual ☐
   - Partnership ☐
   - Corporation ☐
   - Other(Specify ☐
   - _____
   - _____
3. Government
   - ☐ State _____
   - ☐ County _____
   - ☐ City _____
   - ☐ Other(Specify)
   - _____
   - _____

B. Statement of costs of services from Related Organizations

1. Is the amount of costs to be reimbursed by the MEDICAID Program, are any costs included which are the result of transactions with a related organization?

Yes ☐ No ☐ (If "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Costs incurred as the result of transactions with related organizations.

Schedule	Line #.	Item	Amount

D. Name & percent of direct or indirect ownership of the related organization.

Name of Owner	Name of Related Organization	Percent

E. Statement of Compensation of Owners

Name	Title & Function	Percent of Customary Work Week Devoted to Business	Partners % of Operating Profit or Loss	Corp. Off. % of Vendor's Stock Owned	Total Compensation

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For The Period from _____
to _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

Name	Title	Percent of Customary Work Week Devoted to Business	Percent of Period Employed	Total Compensation for the Period

G. Has the facility had a change of ownership in the past fiscal year? A change of ownership is defined as the transfer of assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes ☐ No ☐

If yes, indicate the new owners and the percent owned. (If corporate owned, list individuals.)

Name	Percent Owned

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of in accordance with applicable program directives, except as noted.

(Signed) _____
Officer or Administrator of Facility

_____
Title

ANNUAL COST REPORT
SCHEDULE B
STATEMENT OF INCOME AND EXPENSES

VENDOR NAME: VENDOR NUMBER FYE

1. Total Patient Revenues		
2. Less: Allowances and discounts on patients' accounts		
3. Net Patient Revenues		$ -
4. Less: Total operating expenses		
5. Net income from services to patients		$ -
OTHER INCOME		
6a. Unrestricted contributions, donations, bequests, etc.		
6b. Restricted contributions, donations, bequests, etc.		
7a. Income from unrestricted investments		
7b. Income from restricted investments		
8. Vending machine commission		
9. Revenue from meals sold to employees and guests		
10. Revenue from sale of drugs, supplies, etc., sold to non-patients		
11. Revenue from telephone and telegraph service		
12. Revenue from rental of non-patient facilities		
13. Revenue from Beauty/Barber Shop		
14. Purchase discounts		
15. Other (specify)		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31. Total other income		-
32. Total of line 5 and line 31		-
OTHER EXPENSES (Specify)		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		
49. Total other expenses		
50. NET INCOME FOR THE PERIOD (line 32 less line 49)		

ANNUAL COST REPORT
SCHEDULE C
BALANCE SHEET AND COMPUTATION OF EQUI

VENDOR NAME: VENDOR NUMBER: FYE

ASSETS

		(1) Per Books	(2) Adjustments	(3) Balance
	Current Assets			
1.	Cash			$ -
2.	Notes and Accounts Receivable			$ -
3.	Other Receivables			$ -
4.	Less: Allowance for Uncollectable Accounts			$ -
5.	Inventory			$ -
6.	Prepaid Expenses			$ -
7.	Investments			$ -
8.	Other (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
9.	*Total Current Assets*	$ -	$ -	$ -
	Fixed Assets			
10.	Land			$ -
11.	Building and Leasehold Improvements			$ -
12.	Less: Accumulated Depreciation			$ -
13.	Fixed Equipment			$ -
14.	Less: Accumulated Depreciation			$ -
15.	Major Movable Equipment			$ -
16.	Less: Accumulated Depreciation			$ -
17.	Motor Vehicles			$ -
18.	Less: Accumulated Depreciation			$ -
19.	Minor Equipment			$ -
20.	Less: Accumulated Depreciation			$ -
21.	*Total Fixed Assets*	$ -	$ -	$ -
	Other Assets			
22.	Investments			$ -
23.	Lease Deposits			$ -
24.	Due from Owners or Officers (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
25.	Other (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
26.	*Total Other Assets*	$ -	$ -	$ -
27.	**Total Assets**	$ -	$ -	$ -

ANNUAL COST REPORT
SCHEDULE C (cont.)
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

LIABILITIES

	Current Liabilities	(1) Per Books	(2) Adjustments	(3) Balance
28.	Accounts Payable			$
29.	Notes Payable			
30.	Current Portion of Long Term Debt			
31.	Salaries and Fees Payable			
32.	Payroll Taxes Payable			
33.	Income Taxes Payable			
34.	Deferred Income Payable			
35.	Other (Specify)			
36.	*Total Current Liabilities*	$ -	$ -	$ -
	Long Term Liabilities			
37.	Mortgage Payable			$ -
38.	Notes Payable			
39.	*Total Long Term Liabilities*	$ -		$ -
40.	**Total Liabilities**	$ -	$ -	$ -

CAPITAL AND OWNERS' EQUITY

41.	Common Stock			$ -
42.	Preferred Stock			
43.	Treasury Stock			
44.	Retained Earnings			
45.	Other (Specify)			
46.	**Total Capital and Owners' Equity**	$ -	$ -	$ -
47.	**Total Liabilities and Capital**	$ -	$ -	$ -

ANNUAL COST REPORT
SCHEDULE C-1
BALANCE SHEET AND EQUITY CAPITAL ADJUSTMENTS

VENDOR NAME: VENDOR NUMBER: FYE

ITE	EXPLANATION	AMOUNT	CLASSIFICATION ADJUSTED ACCOUNT	LINE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56	TOTAL	$ -		

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ANNUAL COST REPORT -- SCHEDULE D-1 -- NURSING SERVICES COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloc. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloc. of Costs
1	Director of Nursing Salary							
2	R.N. Salaries							
3	L.P.N. Salaries							
4	C.M.A. Salaries							
5	Aides Salaries							
6	Other Salaries_							
7	Other Salaries_							
8	Other Salaries_							
9	*Subtotal-Salaries*							
10	Employee Benefits Reclassification							
11	Nursing Contracted Services							
12	Medical Records Salaries							
13	Medical Director Fees							
14	Pharmacy Consultant Fees							
15	Physician Services							
16	Nursing Education & Training							
17	Nursing Travel Expense							
18	Medical Supplies							
19	Adult Diapers & Underpads							
20	Nursing Equipment Rental							
21	Nursing Small Equip. Purchases							
22	Other Expense_							
23	Other Expense_							
24	Other Expense_							
25	Other Expense_							
26	Other Expense_							
27	Other Expense_							
28	Other Expense_							
29	Other Expense_							
30	Other Expense_							
31	Other Expense_							
32	Other Expense_							
33	Other Expense_							
34	*Total*							

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ANNUAL COST REPORT -- SCHEDULE D-2 -- OTHER CARE RELATED COSTS

VENDOR NAME:

VENDOR NUMBER:

FYE

	(1) Care Related	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs
1	Activities Salaries							
2	Social Services Salaries							
3	Other Salaries_							
4	Other Salaries_							
5	Other Salaries_							
6	*Subtotal-Salaries*							
7	Employee Benefits Reclassification							
8	Activities Supplies							
9	Social Services Supplies							
10	Training & Education Expense							
11	Travel Expense							
12	Other Expense_							
13	Other Expense_							
14	Other Expense_							
15	Other Expense_							
16	Other Expense_							
17	Other Expense_							
18	Other Expense_							
19	Other Expense_							
20	Other Expense_							
21	Other Expense_							
22	Other Expense_							
23	Other Expense_							
24	Other Expense_							
25	Other Expense_							
26	Other Expense_							
27	Other Expense_							
28	Other Expense_							
29	Other Expense_							
30	Other Expense_							
31	Raw Food							
32	*Total*							

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

PAGE 1

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
	Dietary								
1	Dietary Salaries								
2	Other Salaries_								
3	Other Salaries_								
4	Other Salaries_								
5	*Subtotal-Salaries*								
6	Employee Benefits Reclassification								
7	Dietary Consultant Fees								
8	Dietary Supplies								
9	Equipment Rental								
10	Small Equipment Purchases								
11	Other Dietary Expense_								
12	Other Dietary Expense_								
13	Other Dietary Expense_								
14	Other Dietary Expense_								
15	Other Dietary Expense_								
16	Other Dietary Expense_								
17	Other Dietary Expense_								
18	Other Dietary Expense_								
19	Other Dietary Expense_								
20	*Total Dietary Expense*								
	Housekeeping & Plant Operation								
21	Housekeeping Salaries								
22	Plant Oper. & Maint. Salaries								
23	Other Salaries_								
24	Other Salaries_								
25	Other Salaries_								
26	*Subtotal-Salaries*								
27	Employee Benefits Reclassification								
28	Housekeeping Supplies								
29	Plant Oper. & Maint. Supplies								
30	Equipment Rental								
31	Repairs & Maintenance-Building								

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

OR NAME: VENDOR NUMBER: FYE

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Allocn. of Costs	(8) Non-Certified & Non-Nursing Fac. Allocn. of Costs	(9) Ancillary Hospital-Based Facility Only
32 Repairs & Maintenance-Equipment								
33 Repairs & Maintenance-Grounds								
34 Small Equipment Purchases								
35 Gas								
36 Electricity								
37 Water & Sewage								
38 Garbage Pick-up								
39 Contracted Services								
40 Pest Control Services								
41 Property Taxes								
42 Insurance-Property, Plant & Equip.								
43 Other Hskg. & Plant Op._								
44 Other Hskg. & Plant Op._								
45 Other Hskg. & Plant Op._								
46 Other Hskg. & Plant Op._								
47 Other Hskg. & Plant Op._								
48 Other Hskg. & Plant Op._								
49 Other Hskg. & Plant Op._								
50 Other Hskg. & Plant Op._								
51 Other Hskg. & Plant Op._								
52 Other Hskg. & Plant Op._								
53 Other Hskg. & Plant Op._								
54 Other Hskg. & Plant Op._								
55 Other Hskg. & Plant Op._								
56 *Total Housekeeping & Plant Oper.*								
Laundry								
57 Laundry Salaries								
58 Other Salaries_								
59 Other Salaries_								
60 Other Salaries_								
61 *Subtotal-Salaries*								
62 Employee Benefits Reclassification								
63 Laundry Supplies								
64 Linens & Bedding								

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE PAGE 3

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Allocn. of Costs	(8) Non-Certified & Non-Nursing Fac. Allocn. of Costs	(9) Ancillary Hospital-Based Facility Only
65	Laundry Contracted Services								
66	Other Laundry Expense_								
67	Other Laundry Expense_								
68	Other Laundry Expense_								
69	Other Laundry Expense_								
70	Other Laundry Expense_								
71	Other Laundry Expense_								
72	Other Laundry Expense_								
73	Other Laundry Expense_								
74	Other Laundry Expense_								
75	*Total Laundry Expense*								
	Administrative & General								
76	Salaries-Officers								
77	Salaries-Administrator								
78	Salaries-Office Staff								
79	Other Salaries_								
80	Other Salaries_								
81	Other Salaries_								
82	*Subtotal-Salaries*								
83	Management Fees								
84	Home Office Costs								
85	Board of Directors Fees								
86	FICA								
87	Workmen's Compensation								
88	Unemployment Insurance								
89	Medical Insurance								
90	Life Insurance								
91	Telephone								
92	Dues & Subscriptions								
93	Office Supplies								
94	Equipment Rental								
95	Printing & Postage								
96	Legal Fees								
97	Accounting Fees								

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Allocn. of Costs	(8) Non-Certified & Non-Nursing Fac. Allocn. of Costs	(9) Ancillary Hospital-Based Facility Only
98	Contracted Services								
99	Utilization Review								
100	Travel & Seminars								
101	Advertising-Help Wanted								
102	Advertising-Other								
103	Small Equipment Purchases								
104	Licenses & Fees								
105	Interest Expense-Non-Capital								
106	Other Expense_								
107	Other Expense_								
108	Other Expense_								
109	Other Expense_								
110	Other Expense_								
111	Other Expense_								
112	Other Expense_								
113	Other Expense_								
114	Other Expense_								
115	Other Expense_								
116	Other Expense_								
117	Other Expense_								
118	Other Expense_								
119	Other Expense_								
120	Other Expense_								
121	Other Expense_								
122	Other Expense_								
123	Other Expense_								
124	Other Expense_								
125	Other Expense_								
126	Other Expense_								
127	Other Expense_								
128	Other Expense_								
129	Other Expense_								
130	HEALTH CARE PROVIDER TAX								
131	*Total Admin. & General Exp.*								

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ANNUAL COST REPORT -- SCHEDULE D-4 -- CAPITAL COSTS

VENDOR NAME:

VENDOR NUMBER:

FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
1	Depreciation-Building								
2	Depreciation-Equipment								
3	Interest Expense-Capital Related								
4	Rent								
5	Land Improvements								
6	Leasehold Improvements								
7	Amortization of Start-up Costs								
8	Other Capital Costs_								
9	Other Capital Costs_								
10	Other Capital Costs_								
11	Other Capital Costs_								
12	Other Capital Costs_								
13	Other Capital Costs_								
14	Other Capital Costs_								
15	Other Capital Costs_								
16	Other Capital Costs_								
17	Other Capital Costs_								
18	Other Capital Costs_								
19	Other Capital Costs_								
20	Other Capital Costs_								
21	Other Capital Costs_								
22	Other Capital Costs_								
23	*Total*								

	Grand Totals	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
24	Totals of Schedules D-1 through D-4								
25	Total of Schedule D-5, Column 8								
26	Total Routine CNF Cost								
27	Totals from Schedule D-5								
28	Total Cost								

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